LifeCare Management
Care Management & Caregiver Referrals

CLIENT ASSESSMENT CHECKLIST

Client's Name_____ **Date** _____

Client's Weight (lb): _____

Ambulation

☐ Yes ☐ No Bedridden

☐ Yes ☐ No Dependent on a wheelchair or electric power chair

☐ Yes ☐ No Uses a cane or a walker (with occasional wheelchair assistance)

☐ Yes ☐ No Able to walk unassisted

Mobility

☐ Yes ☐ No Able to use hands: Full___ Partial___

☐ Yes ☐ No Able to use legs: Full ___ Partial ___

Transfer

☐ Yes ☐ No Requires transfers (to a chair, wheelchair, bed, commode/toilet, vehicle, etc.)

☐ Yes ☐ No Uses gait belt or Hoyer lift, or requires lifting skills and strength.

Bathing & personal hygiene

☐ Yes ☐ No Assistance with bathing and hygiene

Toileting/Continence

☐ Yes ☐ No Incontinent

Dressing

☐ Yes ☐ No Assistance with dressing or undressing

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Eating

☐ Yes ☐ No Assistance with feeding

Cognitive & Emotional

☐ Yes ☐ No Needs supervision (due to Alzheimer's ____ Dementia ____)

☐ Yes ☐ No Confusion ____ Disorientation____ Agitation ____ Other _____

Special needs

☐ Yes ☐ No Hard of hearing (Uses hearing aid: Yes ____ No ____)

☐ Yes ☐ No Change bandage or dressing

☐ Yes ☐ No Enema (Occasional ____ Regular ____)

☐ Yes ☐ No Clean/change catheter bag (or condom catheter)

☐ Yes ☐ No Change colostomy bag

☐ Yes ☐ No Using oxygen tank and cannula

Medication

☐ Yes ☐ No Assistance with medications (Reminders ____ Giving ____)

Homemaker Services

☐ Yes ☐ No Light house cleaning, dishes, laundry, etc

☐ Yes ☐ No Prepare/Cook meals

☐ Yes ☐ No Serve prepared meals

☐ Yes ☐ No Shop for groceries and make other errands

Transportation

☐ Yes ☐ No Driving client to appointments, etc

Other Notes: _____

_____

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